Testimony of Barbara Simonetta
President, CT Health Care Associates/NUHHCE/AFSCME
Before the Labor and Public Employees Committee
H.B. 5257: An Act Concerning Hospital Employees and Hospital Conversions
February 27, 2014

My name is Barbara Simonetta and I am President of Connecticut Health Care Associates (CHCA), an affiliate of AFSCME and the National Union of Hospital and Health Care Employees (NUHHCE). Thank you for holding this hearing today. Our union represents nurses and other health care professionals at hospitals throughout Connecticut, including 550 nurses and technical employees at Waterbury Hospital.

Connecticut's nonprofit hospital landscape could be radically changed in a very short period of time, with for-profit hospital chains like Tenet Corporation dominating and consuming private doctor practices everywhere. We ask the State to act now to protect quality care and the thousands of voting caregivers and their families we rely on.

We are here to support House Bill 5257, regarding protections for hospital employees during hospital conversions. We believe this legislation is absolutely essential to protect the employees of Waterbury Hospital if such conversions are even allowed, and believe it should apply to any ownership change. This legislation properly recognizes that "community benefits" include worker protections. Prior to a conversion, the hospital would have to enter into an agreement to maintain current rates of pay, benefits, staffing levels and best practices, and recognize collective bargaining agreements. It also would require 3 official public hearings, which have been nonexistent in this fight. If this bill were law, hospital workers at Waterbury would not be financing the Tenet deal.

Since the Letters of Intent to convert to for-profit were signed with LHP Corporation, then Vanguard and Tenet Corporation, we've seen waves of layoffs, reduction of staffing standards, privatization of services, and more. Our nurses have been in bargaining for a year and are without a contract. They are under severe duress and concerned about understaffing. Tenet and the hospital have made it a precondition of any deal to eliminate our nurses' retirement security -- our solid pension. They have proposed about $1.5 million in concessions, including slashing nearly two weeks of nurses' sick time and other leave, our health benefits and overtime pay while their CEO earns over $500,000 per year. They campaign and say if the nurses don't give up their pension, it's the nurses' fault and the hospital closes. Yet whether this radical step is required is deeply suspect. They haven't made that case or serious proposals for state development funds. It is in their interest to downplay the worth of the hospital for a sale.

We have updated this committee on the progress of our talks, but we are essentially nowhere as of today. We need your help and thank you for your support of this bill. Attached to this testimony are materials for your information.

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For-Profit Hospitals Provide Less Accountability (Except to Shareholders) and Less Community Benefits

For-profit hospitals spend less on uncompensated care, provide lower-quality care, charge higher prices, provide fewer unprofitable services, and are less accountable to the public than non-profit hospitals. For-profit hospitals are in business to make money, and have engaged in dubious business practices to do so.

Executive Summary

- Comparative data from several states indicates that for-profit hospitals spend less on care for the uninsured, as a ratio of their expenses, than non-profit hospitals.

- Conversion to for-profit status is associated with higher mortality (i.e., lower quality), increased profitability, and declining staffing. For-profit hospitals have lower average staffing than non-profits.

- For-profit hospitals often charge higher prices, especially to the uninsured, than non-profit hospitals.

- For-profit hospitals were more likely than non-profits to provide consistently profitable services (and possibly to provide them more than necessary), but were less likely to provide unprofitable services.

- For-profit hospitals are accountable to shareholders and management, not to the public. If hospitals convert to for-profit status, community benefit agreements, careful regulatory oversight, and state legislation may be necessary to guarantee that high-quality services are available to the community.

- For-profit hospitals have a sordid history, and have frequently paid millions of dollars to settle claims that they overbilled Medicare or provided unnecessary surgeries. Recently, the State of Georgia joined a lawsuit against one for-profit firm, Tenet Healthcare, alleging Medicaid fraud and kickbacks.

For-Profit Hospitals Provide Less Care for the Uninsured in Many States

A 2005 study by the federal Government Accountability Office (GAO) looked at five states and found differences between for-profit and non-profit hospitals as far as charity care (also called uncompensated care, i.e., care for the uninsured and the poor). The following chart, using 2003 data, shows ratios of uncompensated care costs to total patient operating expenses, by hospital ownership category:

State	Non-profit	For-profit
California	3.2	3.4
Florida	5.5	4.3
Georgia	6.9	5.4
Indiana	4.3	2.0
Texas	6.7	4.8

Thus, while non-profits and for-profits in California allocated substantially equal shares of operating expenses to uncompensated care, in Florida, Georgia, Indiana, and Texas, non-profits allocated 28%, 28%, 215%, and 40%, respectively, more of expenses toward charity care than did their for-profit peers.[1]

The Congressional Budget Office (CBO) also examined this five-state data set. The CBO assessed the effect of the observed difference between non-profits and for-profits in providing uncompensated care:

> That estimated difference corresponds to non-profit hospitals in the five selected states providing between $100 million and $700 million more in uncompensated care than would have been provided if they had been for-profits.[2]

Other data, although anecdotal, backs up this finding. In Oregon, the Lund Report headlined an April 2013 article, "For-Profit Hospitals Skimp on Charity Care." The story examined hospitals in Oregon:

> Oregon's two for-profit hospitals are among the stingiest hospitals in the state when it comes to providing care for the poor.
>
> Willamette Valley Medical Center spent less than 1 percent of patient revenue on charity care in 2011, a tenth the average of its peers, according to a Lund Report review of the state's major hospitals. And McKenzie-Willamette Medical Center, the only other major for-profit hospital in Oregon, spent 3.2 percent of patient revenue on charity care.
>
> Every other sizable hospital spent at least 5 percent of patient revenue on charity care, with spending averaging 9 percent across the state.[3]

For-Profit Hospitals Provide Lower-Quality Care

In a 2002 study, "Are for-profit hospital conversions harmful to patients and to Medicare?," scholars answered in the affirmative:

> We find that 1-2 years after conversion to for-profit status, *mortality of patients, which is difficult for outsiders to monitor, increases while hospital profitability rises markedly and staffing decreases*.[4] (Emphasis added.)

A 2006 Harvard Medical School study examined quality by ownership, for three common conditions. A press release on the study was titled "Not-for-profit hospitals, more nurses, and greater availability of technology services mean better care for patients." One of the study's authors observed, "Our study supports the importance of adequate nursing care to the quality of treatment patients receive."[5] The study itself concludes, "Patients are more likely to receive high-quality care in not-for-profit hospitals and in hospitals with high registered nurse staffing ratios and more investment in technology."[6]

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[1] http://www.gao.gov/new.items/d05743t.pdf.; data from Figure 3.
[2] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf.
[3] http://www.thelundreport.org/resource/for_profit_hospitals_skimp_on_charity_care.
[4] http://dukespace.lib.duke.edu/dspace/bitstream/handle/10161/2632/out.pdf (abstract).
[5] http://web.med.harvard.edu/sites/RELEASES/html/12_11Landon.htm.
[6] http://www.ncbi.nlm.nih.gov/pubmed/17159018.

A 2013 study, "Hospital Performance Differences by Ownership," cited the following findings:

> Not-for-profit church-owned hospitals save more lives, release patients from the hospital sooner, and have better overall patient satisfaction ratings.
>
> All not-for-profit hospitals combined (both church-owned and other) performed significantly better than for-profit hospitals... in HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems] score, risk-adjusted patient safety, [and] 30-day mortality.
>
> For-profit hospitals significantly outperformed other ownership categories in core measures, expense control, and profit from operations....
>
> The for-profits, however, performed significantly worse than peers on HCAHPS.[7]

Becker's Hospital Review cited 2010 data showing that at every quartile of the staffing distribution (from highest to lowest staffing), for-profit hospitals had fewer full-time employees per adjusted occupied bed than non-profit hospitals. The differences were significant, from 12% to 17% depending on the quartile.[8]

For-Profit Hospitals Often Charge Higher Prices

A 2004 study discussed both quality and cost distinctions between for-profit and non-profit hospitals:

> It has been shown that patients cared for at private for-profit hospitals have higher risk-adjusted mortality rates than those cared for at private not-for-profit hospitals. Private for-profit hospitals result in higher payments for care than private not-for-profit hospitals.[9]

Becker's Hospital Review also commented on the high pricing, and lack of restrictions on pricing, at for-profit hospitals (which are not covered by the federal Affordable Care Act's limits on non-profit pricing):

> Rapid growth in hospital markups for uninsured patients at for-profit hospitals is driving up medical bills across the country, drawing criticism as low-income patients land bills they struggle to pay, according to an *Atlanta Journal-Constitution* report.[10]

Many researchers have criticized huge hospital markups, in both the non-profit and for-profit context, for uninsured patients. Commenting on a 2007 *Health Affairs* study, a health care law firm's blog noted, "Predictably, for-profit hospitals had a higher mark-up rate than their non-profit counterparts."[11]

Referring to the same *Health Affairs* study, the *Washington Post* observed, "The charge-to-cost (markup) ratio at for-profit hospitals was 4.10, compared to 2.49 for public hospitals."[12] The study shows markups

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[7] http://www.100tophospitals.com/assets/HOSP_12678_0513_100TopHopPerfOwnershipPaper_RB_WEB.PDF.
[8] http://www.beckershospitalreview.com/lists/200-hospital-benchmarks-october-2012.html, questions 89 and 90.
[9] http://www.pnhp.org/news/care.pdf.
[10] http://www.beckershospitalreview.com/hospital-management-administration/lack-of-restrictions-on-for-profit-hospital-markups-draw-criticism.html.
[11] http://www.poppelawfirm.com/library/study-shows-unfair-billing-practice-for-uninsured-patients.cfm.
[12] http://www.washingtonpost.com/wp-dyn/content/article/2007/05/08/AR2007050800576.html.

at non-profits averaging 2.99. Thus, for-profit hospital markups were 37% higher than non-profit markups.[13] (The CBO analysis cited above also found that "non-profits charge lower prices or markups.")

For-Profit Hospitals Focus on Profitable Services at the Expense of Unprofitable Services

A 2007 study examined differences in ownership in a more granular fashion, comparing the probability that for-profit, non-profit, and government hospitals would provide a profitable service (open heart surgery) and an unprofitable service (emergency psychiatric care). The study found that for-profit hospitals were more likely to offer the profitable service, but less likely to offer the unprofitable service:

> In direct contrast to the provision of open-heart surgery, for-profits are less likely than nonprofits, which in turn are less likely than government hospitals, to offer the unprofitable service of psychiatric emergency care. Therefore, once again, corporate ownership plays a role in service offerings. On average from 1988 to 2000, 41% of for-profit hospitals were predicted to offer psychiatric emergency services, compared to 48% of nonprofit hospitals and 56% of government hospitals. Again, these are large differences. For-profits are 15 percentage points less likely than government hospitals to offer psychiatric emergency services.[14]

The advocacy group California Watch offers recent data supporting this insight about profitable services:

> A database compiled from state birthing records revealed that, all factors considered, women are at least 17 percent more likely to have a Cesarean section at a for-profit hospital than at one that operates as a non-profit. *A surgical birth can bring in twice the revenue of a vaginal delivery....* Women, whose pregnancies were deemed to be low-risk, had a nine percent chance of giving birth by C-section at the nonprofit Kaiser Permanente Redwood City Medical Center, for example, while at the for-profit Los Angeles Community Hospital, women had a 47 percent chance of undergoing a surgical birth.[15] (Emphasis added.)

For-Profit Hospitals Are Not Accountable to the Public

Local community control would be lost, or at a minimum severely undermined, by the transition of a hospital from a non-profit to a for-profit entity. Non-profit entities typically have governing boards with community representatives. Moreover, in return for their tax-exempt status, they are expected to provide certain benefits to the community. By contrast, for-profit entities are in business to turn a profit.

This is why strong protections for the community need to be negotiated in formal agreements, provided in legislation, or guaranteed by careful government oversight in cases where non-profit entities become for-profit entities. Converting non-profit hospitals to for-profit entities without protections is a bad idea.

A chart from Health First, an integrated non-profit provider in Florida, shows major governance distinctions between the two forms of ownership, and how these distinctions may affect communities:[16]

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[13] http://content.healthaffairs.org/content/26/3/780/T1.expansion.html.
[14] http://papers.ssrn.com/sol3/papers.cfm?abstract_id=964961.
[15] http://www.blogher.com/forprofit-hospitals-performing-more-csections.
[16] http://www.health-first.org/about_us/not_for_profit.cfm.

Not-for-profit/community-minded	Investor-owned
Assets stay in the community.	Assets belong to investors/owners.
Local board of trustees serve without pay and balance financial decisions with community concerns.	Major decisions are often made by individuals outside the community who emphasize creating profits for the stockholders.
Not for "private" profit; no private person or corporation makes any profit.	Stockholders might be physicians who practice at the hospital; community members are generally not allowed to purchase stock.
All income above expenses is used to improve the health of the community.	Profits often leave the community.
Provides a full spectrum of care — education, prevention, and treatment — that benefits all members of the community.	Provides a full range of care that benefits the community they serve; however, focus is also placed on how to best serve their investors.

For-Profit Hospitals Have a Troubled History (see separate document for source material covering Tenet)

Tenet Healthcare, a large for-profit hospital chain, is a case in point. In 2003, Tenet paid $54 million to government authorities to settle charges that doctors at a Tenet hospital in Redding, CA diagnosed and performed unnecessary cardiac surgeries. Tenet later paid $395 million to settle lawsuits by patients who had the surgeries. (In settlements, Tenet generally neither officially admits nor denies wrongdoing.)

In 2006, Tenet settled a case involving overbilling Medicare, for $900 million. In 2009, it paid $85 million to settle claims that it cheated California workers out of overtime pay. In 2012, it settled yet another case for $42.5 million, and in August 2013, the Attorney General of Georgia joined a suit against the firm, alleging a "massive kickback scheme." The company paid no federal income taxes for 2008-2010, despite massive profits of $415 million for those years, and despite lavish compensation for executives.

Summary

- State-level data indicates that for-profit hospitals provide less charity care than non-profit hospitals.
- For-profit hospitals tend to have lower staffing and to provide lower-quality care than non-profits.
- Not surprisingly, for-profit hospitals perform well on financial metrics, partly by charging high prices.
- For-profits are more likely to offer profitable services, and less likely to offer unprofitable ones, than non-profits. There is strong evidence that some for-profit hospitals provide unnecessary procedures.
- For-profits owe their first duty to shareholders. The community should insist on specific protections.
- For-profit hospital firms have paid huge amounts to settle allegations about their business practices.

A Tenet Healthcare Timeline: Excerpts of Critical Media Coverage and Reports from 2003 through 2013 (2014)

Tenet to pay $54M to settle disputed surgery case

By Julie Appleby, USA TODAY, August 7, 2003

Tenet Healthcare (THC) will pay a $54 million fine, but will not face civil or criminal charges, to settle allegations that two doctors working in its Redding, Calif., hospital performed unnecessary cardiac procedures.

The fine — $51.3 million to the federal government and $2.65 million to the state — covers allegations that the hospital billed Medicare, Medicaid and the military's Tricare program for unnecessary procedures from 1997 to 2002.[1]

Tenet Healthcare Agrees to Sell Redding, Calif., Medical Center

April 17, 2004 | The Sacramento Bee, Calif. Knight Ridder/Tribune Business News

Apr. 17--Tenet Healthcare Corp. announced Friday that it has reached agreement to sell Redding Medical Center, its hospital at the center of numerous surgery and billing probes, to Hospital Partners of America Inc.

Under the terms of the deal, HPA, a privately held company based in Charlotte, N.C., would purchase the Redding hospital for approximately $60 million.

The sale, ordered by federal regulators in December as a condition for the Redding hospital to keep billing Medicare and other government health programs, is expected to be completed by June 30, Tenet officials said. ...

$395 Million Payment to Settle Unnecessary-Surgeries Suits

Published: December 22, 2004 (New York Times)

Tenet Healthcare said yesterday that it would pay $395 million to settle litigation with patients who are accusing one of its hospitals of performing unnecessary heart surgeries.

Tenet, which also faces a government investigation into Medicare billing, among other inquiries, said it would set up a $395 million fund to be distributed among at least 750 patients who were treated at the hospital, Redding Medical Center in California.

The company said the fund would cause Tenet to breach certain covenants of its bank line of credit, which is undrawn. That will cause the company to terminate its credit line before the end of the year.

[1] http://usatoday30.usatoday.com/money/industries/health/2003-08-06-tenet-settlement_x.htm.

Although putting the lawsuits to rest removes some uncertainty, the hospital operator faces bigger hurdles before its legal woes are under control, Robert M. Mains, an analyst at Advest, said.

"Some of the other stuff they are being sued for are more systemic issues," like Medicare payments and litigation in San Diego over physician relocation agreements, Mr. Mains said.

"Is Tenet over the hump? They have to get some of the others settled first," he said.

The company settled a federal investigation of the Redding center for $54 million last year. The company was essentially forced to sell the Redding operation because the government threatened to exclude the hospital from the Medicare program.[2]

Tenet Healthcare To Sell 11 Hospitals To Help Cover Cost Of Settlement

Article Date: 04 Jul 2006 - 17:00 PDT – Medical News Today

Tenet Healthcare on Thursday said it will sell 11 hospitals to raise money for a $900 million settlement with the Department of Justice announced earlier this week and to improve the hospital network's efficiency, the *Miami Herald* reports (Dorschner, *Miami Herald*, 6/30). The settlement covers a DOJ investigation into inflated outliers -- payments hospitals receive from Medicare for treating the sickest patients -- that were first questioned in October 2002. The settlement also resolves a DOJ civil suit that accused Tenet of improper Medicare coding, as well as allegations from U.S. attorneys of improper physician recruitment in El Paso, Texas; Los Angeles; Memphis, Tenn.; New Orleans; St. Louis; and San Francisco. Tenet will pay $725 million over four years and also will waive its claim on $175 million in past Medicare payments (*Kaiser Daily Health Policy Report*, 6/29). Among the hospitals for sale are four of Tenet's five New Orleans-area hospitals and three of its five Philadelphia-area hospitals (Appleby, *USA Today*, 6/30). Tenet also plans to sell three Florida hospitals (*Miami Herald*, 6/30). San Diego-based Alvarado Hospital, where Tenet previously settled charges of improper physician kickbacks, has been on the market since May (Yi, *Los Angeles Times*, 6/30). Tenet said it expects to find buyers for the hospitals despite some financial problems at the facilities (Goldstein, *Philadelphia Inquirer*, 6/30). Tenet CEO Trevor Fetter told analysts that the company will immediately pay $470 million to the government. The company then will pay a total of $275 million plus interest in 12 quarterly payments from November 2007 to August 2010. Company officials said spending for new technology at some of Tenet's remaining 57 hospitals will rise by nearly $800 million this year. The higher spending is "aimed at attracting doctors back to Tenet hospitals," which have had difficulty remaining competitive in recent years because of the company's legal problems, *USA Today* reports. A Securities and Exchange Commission inquiry into Tenet's Medicare billing practices is still unresolved.[3]

[Tenet signed a related corporate integrity agreement with the Justice Department in the fall of 2006.][4]

O.C. hospital owner to pay $85M to settle OT dispute

Tenet Healthcare will settle with workers who say they were systematically denied overtime.

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[2] http://query.nytimes.com/gst/fullpage.html?sec=health&res=9E05E4DE1030F931A15751C1A9629C8B63.
[3] http://www.medicalnewstoday.com/releases/46409.php.
[4] http://oig.hhs.gov/fraud/cia/agreements/TenetCIAFinal.pdf. See also DOJ news release at http://www.justice.gov/opa/pr/2006/June/06_civ_406.html.

By COURTNEY PERKES / The Orange County Register
Tenet Healthcare, the owner of three Orange County hospitals, has agreed to pay $85 million to settle claims that nurses and other 12-hour-shift employees were denied extra pay after a change in California law entitled them to overtime.

Statewide, roughly 23,000 current and former Tenet hospital employees qualify for cash payments. Attorneys declined to disclose amounts, but Pagaduan said he's heard the ranges are from $150 to $30,000.

The case centered on Tenet's "California differential" pay scale, according to court documents. The suit alleged that to avoid overtime costs, Tenet lowered the hourly pay rate for employees when they worked more than eight hours a day. That meant that while technically earning overtime, their net wages remained the same as before.[5]

For Hire: Lobbyists or the 99%? How Corporations Pay More for Lobbyists Than in Taxes

A report by Public Campaign, December 2011

[This report showed that for 2008-2010, Tenet realized $415 million in profits, paid a *negative* 12% tax rate (i.e., received refunds) totaling $48 million, and spent $3.4 million lobbying the federal government.

The report also documented that in 2008, Tenet paid its top five executives $20,209,305, an average of over $4 million each. Two years later, in 2010, Tenet paid its top five executives 19% more, or $24,053,996, an average of $4.8 million.[6] Note: More updated information shows continuing excessive pay. For example, CEO Trevor Fetter's total compensation was $34.1 million for the years 2010-2012. Tenet's top executives have a defined benefit pension plan, which the firm justifies as a recruitment and retention tool.][7]

Department of Justice

Office of Public Affairs -- FOR IMMEDIATE RELEASE, Tuesday, April 10, 2012
Dallas-based Tenet Healthcare Pays More Than $42 Million to Settle Allegations of Improperly Billing Medicare; Settlement Related to Company's Inpatient Rehabilitation Facilities

Tenet Healthcare Corporation has agreed to pay the United States $42.75 million to settle allegations that it violated the False Claims Act by overbilling the federal Medicare program, the Justice Department announced today.

The settlement resolves allegations pertaining to the various inpatient rehabilitation facilities (IRFs) that Dallas-based Tenet has owned and operated throughout the country. IRFs are designed for patients who need an intense rehabilitation program that requires a multidisciplinary, coordinated team approach to improve their ability to function. Because the patients treated at these facilities require

[5] http://www.ocregister.com/articles/tenet-39472-overtime-pay.html.
[6] http://publicampaign.org/sites/default/files/ReportTaxDodgerLobbyingDec6Final_rev.pdf.
[7] http://www.tenethealth.com/Investors/Documents/Proxy,%2010-K%20and%2010-Q/FINAL%20Proxy%20Statement.pdf.

more intensive rehabilitation therapy and closer medical supervision than is provided in other settings, such as acute care hospitals or skilled nursing facilities, Medicare generally pays IRFs at a higher rate for rehabilitation care than it pays for such care in other settings.

The Justice Department alleged that, between May 15, 2005, and Dec. 31, 2007, Tenet improperly billed Medicare for the treatment of patients at its IRFs when, in fact, these patient stays did not meet the standards to qualify for an IRF admission. Today's settlement is the United States' single largest recovery pertaining to inappropriate admissions to IRFs.[8]

PRESS ADVISORY – Georgia Attorney General

August 1, 2013

Attorney General Sam Olens has intervened in a whistleblower lawsuit against Health Management Associates, Inc. (HMA, Inc.); HMA Monroe, LLC; Tenet Healthcare Corporation and its subsidiaries Atlanta Medical Center, North Fulton Hospital, Sylvan Grove Hospital and Spalding Regional Medical Center; and Clinica de la Mama (Clinica) involving a massive Medicaid fraud scheme related to illegal kickbacks.

Beginning as early as 2000, the defendant hospitals entered into written contracts with Clinca for translation and other services. In reality, the true aim of the Clinica agreements was to achieve increased Medicaid patient referrals by using Clinica to recruit emergency Medicaid patients and steer them to the hospitals. The hospitals would then bill Georgia Medicaid for the associated services.

"These hospitals allegedly paid Clinica kickbacks camouflaged as interpreter service payments to funnel emergency Medicaid patients their way and increase their bottom line," said Olens.

In order to obtain Medicaid funds for the patients recruited by Clinica, the hospitals made numerous false statements testifying that they did not violate the Anti-Kickback Statute. As a result, the defendants received Medicaid funds to which they were not entitled based on the false statements.[9]

Whistleblower suit: Hospitals defrauded Medicaid (*USA Today)*

Kate Brumback, AP Business Writer 2:18 p.m. EDT August 1, 2013

ATLANTA (AP) — Two large hospital operators paid kickbacks to clinics that directed expectant mothers living in the U.S. illegally to their hospitals and filed fraudulent Medicaid claims on those patients, a federal whistleblower lawsuit unsealed late Wednesday said. Naples, Fla.-based Health Management Associates and Dallas-based Tenet Healthcare and their affiliates entered into contracts with clinics operated by Hispanic Medical Management and *Clinica de la Mama* and their affiliates, the lawsuit says. The clinics then referred pregnant women living in the country without authorization to for-profit hospitals operated by HMA and Tenet in exchange for kickbacks from fraudulent Medicaid claims, the lawsuit says.[10]

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[8] http://www.justice.gov/opa/pr/2012/April/12-civ-446.html.

[9] http://law.ga.gov/press-releases/2013-08-01/attorney-general-olens-intervenes-medicaid-fraud-lawsuit-involving-massive.

A billion dollars paid (Journal Inquirer) (Full Article reprinted below)[11]

By Don Michak Journal Inquirer | Posted: Tuesday, November 12, 2013 10:13 am

The big for-profit hospital chain from Texas negotiating to buy Eastern Connecticut Health Network has paid more than $1 billion over the last decade to settle a series of fraud, overbilling, kickback and other allegations by its biggest customer: the federal government.

Tenet Healthcare Corp. also agreed to pay more than half as much - $641 million – to settle hundreds of civil lawsuits as well as an additional $80 million to pay back taxes after an IRS audit.

The payments included $395 million to settle unnecessary surgery complaints involving 769 cardiac patients at a California hospital, $215 million to settle federal class-action lawsuits by investors, and $31 million to end lawsuits on behalf of 106 heart surgery patients at a Florida hospital.

The latter said they suffered severe post-operative infections at the hospital that Florida regulators fined $95,000 for improper infection control after 20 patients died.

The six settlements Tenet made since 2003 with the U.S. Justice Department, the Department of Health and Human Services, and the Securities and Exchange Commission pre-empted civil or criminal charges against the company and stopped its facilities from being excluded from the federal Medicare program.

On at least two of those occasions, Tenet made the agreements without admitting liability or wrongdoing.

But while the first of those deals mandated that Tenet follow a strict "compliance program," the company in a subsequent settlement signed a formal Corporate Integrity Agreement subjecting it to five years of heightened reporting requirements and increased government oversight between 2006 and 2011.

That arrangement led Tenet, now the owner of 77 hospitals in 15 states, to report that it had overbilled Medicare at inpatient facilities it owned or operated. The disclosure led to the company's most recent multimillion-dollar settlement in 2012.

Tenet last year also figured in a study by Citizens for Tax Justice, a nonprofit advocacy and lobbying group in Washington, D.C. The group reported that the company didn't pay federal income tax between 2008 and 2011, when Tenet had a negative 8.2 percent tax rate after collecting a total of $252 million in tax subsidies.

Trip Pilgrim, Tenet's senior vice president for corporate development, said today that nearly all of the settlements were made "prior to the current management team and were resolved more than seven years ago."

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[10] http://www.usatoday.com/story/money/business/2013/07/31/whistleblower-suit-hospitals-defrauded-medicaid/2607219/.

[11] http://www.journalinquirer.com/page_one/a-billion-dollars-paid/article_0a23e19a-4bad-11e3-a118-0019bb2963f4.html

"Today, Tenet is a much different company," he added. "Under our current leadership, the company has implemented strong clinical quality and compliance programs that are widely recognized in the hospital industry."

Pilgrim said Tenet has been "completely open" with the leadership of ECHN and other hospitals the company is seeking to buy in Connecticut, and that Tenet officials stand "behind our strong track record for providing quality care in communities we serve across the country."

ECHN, the nonprofit that owns Manchester Memorial and Rockville General hospitals, originally proposed its sale to Vanguard Health Systems, a Tennessee company that Tenet Healthcare purchased last month.

Morally bankrupt?

Tenet was created in 1995 by reorganizing National Medical Enterprises, a company established in Los Angeles in 1967 that over the next two decades had become embroiled in a series of costly scandals.

In 1994, for example, NME paid $380 million to settle fraud charges lodged by the federal government and 28 states. Two NME units pleaded guilty to eight criminal charges. NME agreed as well to a five-year Corporate Integrity Agreement.

The company also agreed to pay $2.5 million to settle lawsuits filed by 23 former psychiatric patients who alleged they were physically mistreated and falsely imprisoned until their insurance expired.

Stephen Klaidman, a health care expert, ethicist, and former editor and reporter at the New York Times and Washington Post, suggested in a book about a subsequent scandal at a Tenet hospital in California that NME had changed its name "in an attempt to shed its tainted reputation after the psychiatric hospital debacle."

Tenet by 2003, however, still was dealing with a bad reputation. That September U.S. Sen. Charles Grassley, the Iowa Republican who then chaired the Senate Finance Committee, wrote in a letter demanding documents from the company that "in the annals of corporate fraud, Tenet (formerly National Medical Enterprises) ... more than holds its own among the worst corporate wrongdoers."

"Tenet," the senator added, "appears to be a corporation that is ethically and morally bankrupt."

Grassley mounted an investigation of Tenet after the Justice Department in January alleged that the company had fraudulently "upcoded" inpatient claims by manipulating Medicare coding practices to enhance revenue — at the same time the company was under a Corporate Integrity Agreement.

Tenet that August agreed to pay $54 million to resolve the allegations that between 1997 and 2002 doctors at a Redding, Calif., hospital had billed Medicare for unnecessary tests and treatments. The FBI had raided the hospital, and Tenet didn't admit wrongdoing but agreed to a compliance program.

In his 2007 book about the Redding scandal, "Coronary, A True Story of Medicine Gone Awry," Klaidman suggested that Tenet "was bottom line like most corporations — the message was delivered from corporate to the hospitals." There was an "inordinate volume of cardiac procedures" at Redding, he

said, "most of which would generate excessive and undeserved outlier income." He also wrote that people like the two doctors at the center of the controversy "generated very high and escalating revenues and became golden boys."

Klaidman further reported that when the FBI raided the hospital, Tenet was "facing 26 lawsuits relating to the corrupt business practices and unsanitary conditions at seven of its hospitals in various states" and that between 1994 and 2003 Tenet was "the subject of 53 federal investigations."

Tenet in September 2003 announced the resignation of CEO Jeffrey Barbakow. Trevor Fettor took over the job, and today remains in that post. Fettor called the Redding settlement a "strategic business decision" made "to put this matter behind us," the New York Times reported.

Tenet that year also had paid a $95,000 fine in Florida in connection with high infection rates at its Palm Beach Medical Center, the Sun Sentinel newspaper in Florida reported. The penalty covered the hospital's improper control of infection problems as well as its failure to notify health officials when patients with post-operative infections required more surgery.

Meanwhile, the Orange County Register in California reported that Tenet, then the largest hospital owner in that county, had two hospitals with the highest death rates and another with the highest percentage of doctors with disciplinary records. It gave five of Tenet's nine hospitals one- or two–star rankings, but none got its highest four-star ranking. The newspaper also reported that Tenet hospitals submitted the biggest bills for many of the most frequent types of medical cases.

An 'appropriate' settlement

Tenet moved its corporate headquarters to suburban Dallas in 2004.

The company that spring agreed to pay a total of $30.75 million to resolve allegations raised by a whistleblower who was a former Tenet executive. Most of that, $22.5 million, settled allegations by the Justice Department that Tenet's North Ridge Medical Center in Fort Lauderdale in the 1990s had improperly billed Medicare for millions of dollars in referrals from doctors with whom it had financial relationships. The remaining $8.2 million settled allegations that the hospital requested improper reimbursements on its cost reports between 1992 and 2000. Tenet also agreed to meet the conditions of another Corporate Integrity Agreement.

Just before Christmas in 2004, Tenet moved to resolve hundreds of civil lawsuits involving its Redding Hospital and another Florida hospital.

The company said it would establish a $395 million fund to settle lawsuits brought by the 769 Redding patients and their families, a move Fettor reportedly described as a "fair and honorable way to conclude this very sad chapter."

Tenet also said it had agreed to pay $31 million to settle 106 individual lawsuits brought against Palm Beach Medical Center between 1997 and 2002. The plaintiffs — heart surgery patients who complained that they had suffered severe post-operative bacterial infections — had alleged that the infection rate the cardiac unit spiked after Tenet bought the hospital in 1995. They agreed to maintain confidentiality and not comment on the outcome, according to the Sun Sentinel, which reported that 20 patients had died from infections.

The Department of Health and Human Services' office of the inspector general notified Tenet in May 2006 that it had proposed to exclude from the Medicare program a hospital in California owned by the company based on its alleged payment of kickbacks to physicians.

Tenet promptly agreed not only to sell its Alvarado Hospital Medical Center in San Diego but to pay $21 million in a deal with federal prosecutors in California to resolve criminal charges over the alleged kickbacks. It admitted no wrongdoing in the civil settlement.

Three weeks later, Tenet said it had agreed to pay $215 million in cash to settle federal class-action lawsuits brought on behalf of stockholders. Investors asserted the company had misled them about its Medicare claims, and some argued that Tenet had failed to disclose that the FBI had executed search warrants when agents raided the Redding hospital. Tenet said its insurance would cover about $75 million of the settlement, leaving a net cost of $140 million.

Tenet in June then made its biggest settlement with the government, agreeing to pay more than $900 million over the next four years for "alleged unlawful billing practices" in the 1990s. The Justice Department said that in exchange for a release from liability, Tenet would pay:

• More than $788 million to resolve claims that it collected excessive "outlier" payments, higher-than-usual Medicare reimbursements for expensive procedures.

• More than $47 million to resolve claims that it paid kickbacks to physicians to get Medicare patients referred to its facilities and that Tenet billed Medicare for the services ordered or referred by physicians who had a financial relationship with the company.

• More than $46 million to resolve claims that the company engaged in "upcoding," using diagnosis codes it was unable to support or were otherwise improper to get higher Medicare reimbursements.

Fettor in a statement said Tenet had "made mistakes in its conduct before 2003," and in an interview with the Bloomberg news service called the deal "an appropriate and fair settlement we can afford."

Federal regulators step in

To finance the settlement, however, Tenet sold 11 hospitals in four states, including two in New Orleans that had been flooded by Hurricane Katrina. At one of the latter, Memorial Hospital Center, a doctor and two nurses had been charged with second-degree murder of four patients during the storm but a grand jury refused to indict them.

Tenet that fall also signed a Corporate Integrity Agreement, committing to a five-year annual training and compliance contract monitored by independent organizations that would expire in 2011. Under the agreement, the government agreed to release and refrain from instituting any administrative action seeking to exclude Tenet from Medicare, Medicaid, and other federal health care programs for the "investigated conduct."

Near the end of 2006, Tenet also announced that in a settlement with the IRS, following an audit of its tax returns for 1995, 1996, and 1997. The company said would pay $80 million in unpaid taxes and interest.

Federal regulators cost Tenet considerably more money in April 2007, when Tenet agreed to pay a $10 million civil penalty to settle fraud charges against the business and its former president, CEO, general counsel, and chief compliance officer. At issue again was Tenet's use of Medicare "outlier" payments, which the Securities and Exchange Commission said the company's management had realized they could use to inflate revenue "by simply increasing the gross charges set by its hospitals."

The SEC alleged that Tenet had failed to disclose to investors that the company's "strong earnings growth from 1999 to 2002 was driven largely by its exploitation of a loophole in the Medicare reimbursement system" and that once its scheme was revealed, the market value of Tenet stock plunged by more than $11 billion.

The SEC also said that the five-year Corporate Integrity Agreement that National Medical Enterprises had signed in 1994 expired in June 1999, or "about the same time" the outlier scheme was first implemented.

Tenet didn't admit or deny the allegations but agreed to be "permanently enjoined" from violating anti-fraud, reporting, and record-keeping laws.

Ten days after the SEC imposed the $10 million penalty, Tenet announced a new director, John Ellis "Jeb" Bush, who had left his job as governor of Florida three months before. The company "created a special board seat" for the brother of then-President George W. Bush, according to the Associated Press, which reported that he would serve on Tenet board's ethics and nominating committees.

Tenet's most recent settlement came last year, when it agreed to pay the government $42.75 million to settle more Medicare fraud allegations resulting from its own disclosure of "overpayments."

The Justice Department said Medicare generally pays for care at "inpatient rehabilitation facilities" at a higher rate than for less intensive care in other settings, and that between 2005 and 2007 Tenet had improperly billed for "inappropriate admissions" to such facilities it owned or operated across the country.

Tenet said it identified the overpayments in an "internal review" in 2007, and the Justice Department said the company had reported the matter under its Corporate Integrity Agreement.

FEDS JOIN TENET LAWSUIT

BLOOMBERG NEWS

Tenet Healthcare's Atlanta Medical Center in Georgia is seen in this file photo. The Justice Department has formally intervened in a lawsuit accusing Tenet of paying kickbacks and cheating Medicaid and Medicare at hospitals in Georgia and South Carolina.

U.S.: Waterbury Hospital suitor paid kickbacks, plundered Medicaid

BY DON MICHAK
JOURNAL INQUIRER

The federal government has followed through on its threat to join a whistle-blower lawsuit accusing the big hospital chain that is trying to acquire Waterbury Hospital of paying kickbacks and cheating Medicaid and Medicare.

In the move announced Wednesday, the Justice Department formally intervened in the false claims lawsuit against the for-profit hospital chain based in Texas, Tenet Healthcare Corp., which is also seeking to acquire Bristol Hospital and Eastern Connecticut Health Network, which consists of Manchester Memorial and Rockville General hospitals.

The lawsuit alleges that Tenet, four of its hospitals in Georgia and South Carolina, and a Georgia hospital owned by another for-profit chain based in Florida, Health Management Associates, paid kickbacks to obstetric clinics primarily serving undocumented Hispanic women in return for their referral for labor and delivery at the five hospitals.

The kickbacks are alleged to have been paid to clinics run by Hispanic Medical Management/Clinica de la Mama and its related entities in return for their agreement to refer pregnant women for labor and delivery at the hospitals.

The kickbacks of as much as $20,000 per month were disguised as payments for a variety of services, including interpreting, according to the lawsuit.

The hospitals then billed the Medicaid programs in Georgia and South Carolina for the services provided to the referred patients, and, in some instances, also obtained additional Medicare reimbursement based on the influx of poor patients, it says.

Michael J. Moore, the U.S. attorney for the Middle District of Georgia, said Tenet and the hospitals "plundered a system set up for those truly in need."

"This drives up costs for everyone, not just the vulnerable patients and groups like those targeted in this case," Moore added.

The government had warned it might intervene in the lawsuit when it asked the presiding federal judge not to rule in favor of a Tenet motion to dismiss the matter.

Tenet has insisted its agreements with Clinica "were appropriate and provided substantial benefits to women in underserved Hispanic communities" served by its hospitals. It said those services included translation, determination of Medicaid eligibility, and others designed "to improve the delivery of obstetric care and increase the likelihood of a safe birth and a healthy baby while reducing the overall cost to

See **TENET**, *Page* **2C**

TENET: Lawyers argue against false claims

Continued from 1C

state Medicaid programs."

The services, it said, conveyed that the hospitals' "chief concern" was not the women's immigration status, "but rather their well-being and the well-being of their babies."

Tenet's lawyers last month also argued that the lawsuit fails to allege that the hospitals knowingly submitted a false claim.

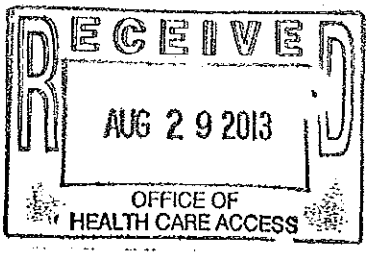
Tenet in November paid the federal government $3.7 million to resolve allegations that for four years its Baptist Health Systems in Texas filed false claims for Medicare reimbursements.

Baptist had been owned by a for-profit chain that Tenet acquired last year, Vanguard Health Systems. The latter made the initial bid for Waterbury and Bristol hospitals and ECHN, which Tenet has pursued since last summer.

The civil settlement in Texas was triggered by a whistle-blower complaint and marked the latest in a series of multimillion-dollar payments to the government over the previous decade. The payments to settle Medicare fraud allegations had amounted to more than $1 billion, but Tenet officials said those deals involved mistakes and misdeeds that had occurred before the company's current leaders took control.

Officials also insisted Tenet is now a "completely different" company and focused on providing quality health care.

Massachusetts Nurses Association MNA National Nurses United



VIA CERTIFIED MAIL

August 26, 2013

Office of the Attorney General
P.O. Box 120
55 Elm Street
Hartford 06106
Attn: Gary W. Hawes, AAG

Commissioner of Public Health
410 Capitol Avenue
Hartford, CT 06134
Attn: Kevin Hansted, Staff Attorney
Attn: Steve Lazarus, Associate Health Care Analyst, OHCA

Re: Certificate of Need Application for a Joint Venture by Greater Waterbury Health Network, Inc., Vanguard Health Systems, Inc.; Docket No. 13-31840-CON; Public hearing date yet to be determined 31839

Dear Mr. Hawes, Hansted, and Lazarus:

Pursuant to the Connecticut Uniform Administrative Procedures Act (UAPA), Connecticut General Statutes (CGS) §§ 4-166 and 4-177a (a) and (b); and §§ 19a-9-26(a) and 19a-9-27 of the Regulations of Connecticut State Agencies, the Massachusetts Nurses Association hereby requests the opportunity to participate in the above proceeding as an intervenor with full procedural rights.

Preliminary Statement & Interest in Participation

Vanguard Health Systems (VHS) and Greater Waterbury Health Network (GWHN) have petitioned your offices for permission to form a joint venture, the terms of which would effectively give Vanguard Health Systems majority ownership of GWHN.

The Massachusetts Nurses Association's (MNA) interest in this proceeding is multi-fold. The MNA represents more than 900 nurses at two hospitals owned and operated by Vanguard Health Systems in Massachusetts. Our experience with Vanguard in Massachusetts and the evidence summarized below and attached to this letter about the company's activities in other states suggests that approving this venture would not be in the best interests of the people of Connecticut, or the patients and nurses at Greater Waterbury Health System.

Vanguard's aggressive growth plan is a significant threat to the hospitals it operates in Massachusetts. Vanguard's acquisition of GWHN would be only the beginning of its expansion into Connecticut, followed by the acquisitions of Bristol Hospital, Manchester Memorial Hospital, and Rockville General Hospital, and beyond. As Vanguard acquires hospital after

hospital, it will also assume the debt burden of each facility, further weighing the system down, despite its difficulties meeting existing financial obligations. In Michigan, for example, Vanguard has failed to fulfill its capital commitments to Detroit Medical Center by tens of millions of dollars and has repeatedly delayed building projects.
And in June, Tenet Healthcare Corp. announced it plan to purchase Vanguard Health Systems. This deal would further indebt Vanguard Health Systems and potentially impact the hospitals Vanguard operates in Massachusetts (see additional information in *VHS's Pending Acquisition by Tenet Healthcare*).

Manner/Extend we propose to participate
The MNA respectfully requests intervenor status with full procedural rights, including the rights to inspect and copy records, present evidence and argument, and cross-examine witnesses.

Summary of Evidence
VHS in Massachusetts
At St. Vincent Hospital, the collective bargaining agreement contains language requiring staffing standards that offer both a manageable workload for nurses and access to safer care for patients. Significantly, the patient safety and staffing protections were won only after a nearly two-month nurses' strike with the previous owner, Tenet Healthcare Corp., which will acquire Vanguard by the end of 2013. However, staffing levels at both campuses of MetroWest Medical Center (where there has not been a strike yet) remain among the lowest in the Boston metro west area. The differences between these two Vanguard operations suggest that, absent the threat of a strike, the corporation will not act on its own to ensure safe nurse staffing levels.

VHS in Michigan
The terms of Vanguard Health Systems and Greater Waterbury Health Network's petition to form a joint venture would give the for-profit health system, VHS, 80% ownership of the Waterbury hospital. In exchange for majority ownership, VHS has made several promises, including a pledge to invest $55 million in "capital items and the development and improvement of ambulatory services."[1] These promises are similar to those made to the State of Michigan and the people of Detroit when it acquired Detroit Medical Center's (DMC) eight hospitals in 2011. Legacy DMC, the organization appointed by the Michigan Attorney General to ensure that VHS meets its commitments reported in two consecutive years that Vanguard made dramatically fewer investments in DMC than promised. Between 2011 and 2012, Vanguard underfunded routine capital expenditures by more than $20 million, and spent $80 million less than promised on specified capital projects.[2] Vanguard also pushed back the deadlines to complete many projects by months and, in some cases, years. And Legacy DMC expressed real concern that the organization was not fulfilling its mission to improve access to care and financial aid for low-income patients.

VHS in Arizona
Vanguard Health System operates Phoenix Health Plan (PHP), a Medicaid managed care system which has provided health coverage to 186,000 consumers in nine Arizona counties for twenty-

[1] Vanguard Health Systems and Greater Waterbury Health Network, "Application for Approval of Joint Venture," p. 1. May 3, 2013.
[2] See attachment: Vanguard Health Systems: Michigan

five years. In January, the Arizona Health Care Cost Containment System (AHCCCS) issued an RFP for those contracts, but in March, Vanguard announced that AHCCCS did not renew its contract with Phoenix Health Plan. Vanguard's failure to secure its long-held contract to provide managed care is the direct result of coming up short vis-à-vis its competitors in a variety of areas, including member-centeredness, disease management, improved outcomes, and cost-savings. It is also clear from evaluators' responses to VHS's performance in many areas that the company refused to provide the State of Arizona with enough information to adequately review its activities, the same charge waged against it in Michigan. Transparency appears to be an ongoing challenge for Vanguard Health Systems.

VHS's Pending Acquisition by Tenet Healthcare

Finally, the pending acquisition of VHS by Tenet Healthcare, expected to close at the end of this calendar year would mean that the State of Connecticut could approve a venture that includes Vanguard Health Systems, which would become a subsidiary of Tenet Healthcare, an organization with a significant history of fraud. In the last ten years, Tenet paid out well over $1 billion to state and federal governments, whistleblowers, patients who were subjected to unnecessary cardiac surgery, and others to settle multiple claims of Medicare fraud in its facilities. In 2006, Tenet even sold off 11 hospitals in four states to finance the settlement of a Medicare fraud case. And beyond its history of fraud, Tenet is also a highly leveraged company, owning 49 hospitals (13,180 licensed beds) and 126 outpatient centers in a dozen states. Assuming Vanguard's holdings would turn Tenet into a more than 20,000-bed (77 acute care hospitals) company operating throughout the United States. The impacts of an operation this scale may include service consolidation, shifting capital priorities, more hospital sales to finance fraud settlements, ongoing problems with safe staffing for patient care, and so on.

It would be prudent for Connecticut regulators to closely scrutinize these factors while considering Vanguard's petition for transfer of ownership of the Danbury and Waterbury hospitals. Since the Vanguard sale to Tenet has already been announced, the most prudent course of action would be to require due diligence of Tenet as well as Vanguard when considering the suitability of the transfer of ownership of the Connecticut facilities.

Conclusion

The MNA will demonstrate that the evidence summarized above, as well as additional evidence presented at the hearing, indicates that Vanguard Health System's business practices in Arizona, Michigan, Massachusetts, and elsewhere show a pattern of refusal to live up to promises, provide transparency to state overseers, or prioritize patient care.

Again, we request that the MNA be granted intervenor status with full procedural rights.

Sincerely,

Donna Kelly-Williams, RN

Donna Kelly-Williams, RN
President

Julie Pinkham

Julie Pinkham, RN
Executive Director

Vanguard Health Systems: Massachusetts

Vanguard Health Systems owns St. Vincent Hospital in Worcester, as well as MetroWest Medical Center, which is comprised of two hospitals: Leonard Morse (Natick) and Framingham Union Hospitals (Framingham). Despite common ownerships, conditions and interest in patient safety vary widely from one hospital to another.

At St. Vincent Hospital, the collective bargaining agreement contains language requiring staffing standards that offer both a manageable workload for nurses and access to safer care for patients. Significantly, the patient safety and staffing protections were won only after a nearly two-month nurses' strike with the previous owner, Tenet Healthcare Corp., which will acquire Vanguard by the end of 2013. However, staffing levels at both campuses of MetroWest Medical Center (where there has not been a strike yet) remain among the lowest in the Boston metro west area. The differences between these two Vanguard operations suggest that, absent the threat of a strike, the corporation will not act on its own to ensure safe nurse staffing levels.

Tenet's pending acquisition of Vanguard Health Systems will mean that it will once again own the three Massachusetts hospitals it sold to VHS less than ten years ago. The announcement has caused concern in Massachusetts as neither Vanguard nor Tenet has indicated what the effect of the purchase will be on patients. A Tenet spokesperson said, "It's too early to say what changes patients may see locally after the acquisition goes through."[1] There are also concerns that the acquisition could impact Vanguard's relationships with other facilities, which include clinical affiliations, joint ventures to purchase community hospitals, and a new cooperative health plan that was only recently approved by the state's Division of Insurance.[2]

[1] Kendall Hatch. "MetroWest Medical Center parent company sold to former hospital owner," *MetroWest Daily News*. June 25, 2013

[2] Robert Weisman. "For-profit hospitals put to test in Mass," *The Boston Globe*. July 12, 2013

Vanguard Health Systems: Michigan

In 2011, Vanguard Health Systems purchased the non-profit Detroit Medical Center (DMC), which operated nine acute and specialty hospitals in the Detroit area. A cornerstone of the deal was Vanguard's pledge to spend $850 million over five years for facility maintenance and upgrades, and new building projects at DMC. The Michigan Attorney General appointed Legacy DMC, a nonprofit organization, to provide oversight of and produce an annual report on Vanguard's compliance with the Purchase & Sales Agreement (PSA).

Routine Capital Expenditures

The PSA required Vanguard to spend $50 million in capital investments in 2011, but actual investments were nearly $14 million short. VHS of Michigan, Inc. claimed that "routine capital spending will exceed $100 million dollars by the end of calendar year 2012 . . . We will come into full compliance."[3] However, by the end of 2012, Vanguard had spent only $63.3 million, nearly $7 million less than projected, and fell short on its two-year commitment by more than $20million.[4]

DMC Routine Capital Expenditures

Year	Planned	Spent	Shortfall
2011	$50m[5]	$36.4m	$13.6m
2012	$70m	$63.3m	$6.7m
	Total Shortfall (2011-2012):		**$20.3m**

Specified Capital Projects

Vanguard also pledged to make $80 million in specific capital expenditures in the first year following its acquisition of DMC. By the end of 2011, however, VHS had spent less than half that amount, and was required to deposit the unspent $42 million in an escrow account.[6] In 2012, the story was the same, as Vanguard's investments in DMC – which included a new pediatrics department and upgraded emergency and operating rooms amounting to more than $240 million – were $40 million less than the minimum required.[7] Once again, Vanguard was required to deposit the remaining $27.8 million in an escrow account as an alternative to making capital improvements.[8]

Among some of the capital project failures or delays noted in the 2011 Annual Report are the following[9]:

- Harper University Hospital (HUH) Surgical services renovation pushed back from June, 2013 to October, 2013
- Pediatric services renovation pushed back
- HUH Lobby renovation planned completion date moved from May, 2012 to October, 2014
- HUH ED expansion pushed back

[3] VHS of Michigan, Inc. 2011 Annual Report (hereafter 2011 Report), p.3

[4] Ibid.

[5] Annual capital expenditures expected to be an average of $70m, but not less than $50m in the first year

[6] VHS of Michigan, Inc. 2011 Annual Report, p.7

[7] JC Reindl. "DMC parent company falls short of required spending," *Detroit Free Press*. April 16, 2013

[8] Bob Herman. "Vanguard Health Systems Falls Short in Detroit Medical Center Capital Funding," *Becker's Hospital Review*. June 7, 2012

[9] Some of these delays or extended timelines are due to modifications to – and expansion of – the original renovations plans

- Corporate Relocation of Mack Parking Deck: In its 2011 report, VHS projected a completion date of December, but in the following report, it moved to March of 2014[10]
- The addition of more ICU beds was pushed back from February of 2012 to January of 2013. But the 2012 Annual Report said the "project has been put on hold pending the outcome" of a "Master Plan review."[11]
- Detroit Receiving Care Unit renovations: "anticipated to be complete by May 2014, approximately 13 months later than the original completion date"[12]
- The Children's New Tower (pediatric services) completion date pushed back to August of 2016. But the timeline changed again and the new projected completion date is a full year later – August, 2017
- In the 2011 report, VHS stated that the HUH Cardiovascular (CVI) & Outpatient Services Bldg (a/k/a Heart Hospital) would be completed in January 2014. However, in the 2012 report, VHS stated that it will be completed in August 2014, claiming that "the scope and schedule have not changed since the last update."[13] This is clearly a misrepresentation, as the date of completion was pushed back eight months
- Sinai-Grace ED/ICU/FAÇADE/Radiology was originally scheduled to be completed December of 2014, but the completion date was pushed back to February, 2015

Transparency

One of the "critical covenants" outlined in the agreement among the Michigan Attorney General, Vanguard Health Systems/VHS of Michigan, and Legacy DMC was "the commitment to implement and publicize the more benevolent charitable care policy."[14] As part of the effort to ensure access to charitable care, VHS was required to establish a hotline to assist individuals in applying for financial aid and Medicaid. But Legacy DMC's report indicated that there is minimal volume on the hotline, stating "the minimal volume on the hotline has proved only negative assurance that there is no systematic denial of care."[15]

Additionally, in its first-year compliance review and report to the Michigan Attorney General's office, Legacy DMC expressed frustration that Vanguard withheld information that would allow it to determine whether DMC provided adequate care and financial assistance to the low income:

> " . . . Legacy DMC views its challenge to be obtaining information from VHS of Michigan on an ongoing basis that adequately demonstrated their effectiveness in the treatment of and proper financial assistance for qualifying individuals."[16]

The oversight body's inability to access sufficient information on Vanguard activities has made it impossible to effectively determine whether DMC is providing the care and additional resources to the patients who need it, or fulfilling the charitable mission of the formerly-nonprofit hospitals it acquired.

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[10] 2011 Report, p.7; VHS of Michigan, Inc. 2012 Annual Report (hereafter, 2012 Report)
[11] 2012 Report, p.4
[12] 2011 Report, p.5
[13] 2011 Report, p.6; 2012 Report
[14] Joe Walsh & Richard Widgre. Legacy DMC. Letter to: Ms. Katharyn Barron, Division Chief, Consumer Protection Division and Charitable Trust Section, Department of Attorney General, State of Michigan. May 30, 2012
[15] Ibid.
[16] Ibid.

Vanguard Health Systems: Arizona

Vanguard Health System operates Phoenix Health Plan (PHP), a Medicaid managed care system which has provided health coverage to 186,000 consumers in nine Arizona counties for twenty-five years. In January, the Arizona Health Care Cost Containment System (AHCCCS) issued an RFP for those contracts.

The RFP process in Arizona required applicants to provide narrative responses to fifteen "Submission Requirements," or criteria used to select contractors. A discussion with the AHCCCS Deputy General Counsel helped clarify the review process.[17] For the first time in Arizona, applicants were ranked not against an ideal, but against one another. Below are the areas in which PHP scored the lowest, along with the scores, a brief description of the Submission Requirement, and the review panel's narrative evaluations:[18]

Submission Requirement #2: Network: Development & Management *(7th)*
(Ensure timely access to care for underserved populations, identify network deficiencies, and manage/improve/sustain network)

- Offeror described processes for managing its network but did not describe in detail how it would use a comprehensive array of data to make network improvements
- Offeror did not address in detail how it would monitor outcomes of process improvements for effectiveness and sustainability

Submission Requirement #3: Program: Data Sharing/Care Coordination *(10th)*
(Using evidenced-based info to improve care coordination, improve outcomes, and create cost efficiencies. Link to implementation of outcome/value-oriented payment models)

- Offeror did not demonstrate use of decision support tools that promote care coordination and improved outcomes at the individual level
- Offeror described limited array of strategies to promote care coordination
- Offeror did not adequately address how payment strategies are designed to promote good outcomes

Submission Requirement #4: Program: Disease Management *(10th)*
(Improving health care outcomes for members with one or more chronic illnesses)

- Offeror did not provide detailed approach for disease management
- Offeror did not describe member-centered approach to care planning and management

Submission Requirement #5: Program: Disease Management *(9th)*
(Coordinating care)

- Offeror included member's empowerment as a goal and affirmed importance of family's participation, but did not clearly describe how the member and his family would be engaged in the care planning process
- Offeror acknowledged member's risks and challenges but did not describe in detail how post-discharge risks would be mitigated

Submission Requirement #6: Program: Medicare Integration/Alignment *(9th)*
(Experience with various Medicare plans, serving members who are enrolled in both Medicare & Medicaid, and increasing/maintaining Medicare & Medicaid enrollment)

- Offeror did not describe distinct approaches for aligned and non-aligned members ("aligned" refers to individuals eligible for both Medicaid and Medicare)
- Offeror did not describe detailed approaches for coordinating with providers
- Offeror did not describe clear and comprehensive process for coordinating care

[17] Phone conversation with Gina Relkin, Deputy General Counsel, AHCCCS Administration, June 10, 2013
[18] Narrative Submission Ranking and Consensus documents, AHCCCS

Submission Requirement #7: Organization: IOM *(9th)*
(IOM is a reference to an Institute of Medicine study on waste in healthcare. This Requirement is about sustainable models that improve outcomes and reduce waste in the system)

- Offeror provided limited description of technology use to improve outcomes
- Offeror's description lacks specificity regarding how DST profiling and predictive modeling software will be used beyond identification members who are dually eligible and diabetic for participation in Alere disease management program
- Offeror provided limited description of information that will be available via web portal
- Offeror provided limited approach to encourage members to actively participate in their care
- Offeror provided limited evidence of a member-centered care delivery approach
- Offeror provided limited description of value-based purchasing strategies to encourage better care and improve outcomes
- Offeror provided little evidence of a culture of innovation and learning

Oral Presentation: *(10th)*
(Quality and medical management reports, processes, interventions, and staffing used if 10% - twice the estimated state average of 5% - or more of PHP members are readmitted to hospital within 30 days)

- Offeror . . . did not demonstrate clearly how processes or staffing were changed in response to the root cause analysis or how data is used to identify or implement interventions at the hospital or physician level. Offeror also indicated that patients readmitted due to medical instability, as a class, were not a priority for intervention under the performance improvement plan
- Offeror did not discuss any changes in staffing to address the higher than average readmission rate noted in the case study. Offeror also stated its goal is to arrange a follow-up visit with member's PCP between 14 and 30 days after discharge; AHCCCS is introducing a performance standard of seven days
- Offeror stated it is exploring incentives for hospitals and hospitalists to reduce readmission rates but did not indicate whether or when such incentives would be introduced
- Offeror mentioned use of the Peer Review Committee for physician education but did not describe clearly escalation of data/trends to the committee level, for development, implementation and monitoring of interventions to reduce the readmission rate

Despite its twenty-five year history as a health plan provider, on March 23, 2013, Vanguard released a statement saying that AHCCCS did not renew its contract with Phoenix Health Plan.[19] That same day, Vanguard requested a capped contract (i.e., PHP could not accept more members) for Pima and Maricopa counties, where more than 60% of its members live. On April 1st, AHCCCS and Vanguard agreed to a three-year capped program for just Maricopa County, where 98,300 – or 53% – of PHP's consumers reside.[20] In exchange, Vanguard agreed not to appeal AHCCCS's refusal to renew the larger contract.

Vanguard's failure to secure its long-held contract to provide managed care is the direct result of coming up short vis-à-vis its competitors in a variety of areas, including member-centeredness, disease management, improved outcomes, and cost-savings. It is also clear from evaluators' responses to VHS's performance in many Submission Requirement areas that the company refused to provide the State of Arizona with enough information to adequately review its activities, the same charge waged against it in Michigan. Transparency appears to be an ongoing challenge for Vanguard Health Systems.

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[19] "Vanguard Health Systems Receives Arizona Medicaid Agency Contract Award Notification," Vanguard press release. March 24, 2013
[20] "Vanguard Health Systems' Phoenix Health Plan Subsidiary Accepts a Capped Contract in Maricopa County," Vanguard press release. April 1, 2013

Vanguard's Debt Overload and Pending Acquisition of by Tenet Healthcare

Vanguard's acquisition of Greater Waterbury Health Network is only the beginning of its planned expansion into Connecticut, followed by the acquisition of Bristol Hospital, Manchester Memorial Hospital, and Rockville General Hospital, and beyond. As Vanguard acquires hospital after hospital, it will also assume the debt burden of each facility, enhancing both its debt load and the potential limitations that debt service would place on commitments to safe staffing levels for patients and necessary capital improvements. And Vanguard already has difficulties meeting existing financial obligations. In Michigan, for example, Vanguard has failed to fulfill its capital commitments to Detroit Medical Center by tens of millions of dollars and has repeatedly delayed building projects. This problem will be further compounded by the significant debt load and debt service obligations that will result from the Tenet acquisition of the Vanguard portfolio.

Tenet Healthcare is a Dallas-based, for-profit healthcare corporation that operates 49 hospitals in ten states, largely in the South, Southeast, and on the West Coast. Tenet owned three hospitals in Massachusetts: St. Vincent Hospital in Worcester and the two MetroWest Medical Center campuses – Leonard Morse (Natick) and Framingham Union (Framingham) – until 2004, when it sold the hospitals to Vanguard Health Systems. In June, Tenet announced that it will purchase Vanguard Health Systems, effectively gaining control of every entity it owns. Concerns over the Tenet acquisition of Vanguard run deep in Massachusetts, where the company's operations in the state were marred by bargaining tactics and unsafe staffing levels that required nurses to strike.

Anxieties over the Tenet takeover extend beyond the Massachusetts border. In Michigan, stakeholders are concerned that Tenet's plan to save $100 to $200 million per year and realize additional earnings in the first year following its acquisition of VHS could only be realized through cuts to services.[21] And just two months ago, Moody's Investors Service placed the ratings of Tenet under review for downgrade, including the company's B1 Corporate Family Rating and B1-PD Probability of Default Rating. The rating action was precipitated by the announcement that Tenet has signed a definitive agreement to acquire Vanguard for a transaction value of $4.3 billion, including the assumption of about $2.5 billion of Vanguard debt. Tenet's acquisition of Vanguard will result in increased leverage and the assumption of a considerable obligation for future capital spending. Additionally, Tenet's history of Medicare fraud has repeatedly cost the company hundreds of millions of dollars and impacted its businesses in several states.

In 2003, Tenet Healthcare paid a $54 million fine to settle allegations that two doctors working at Redding Medical Center in a Redding, California, hospital performed unnecessary cardiac procedures. The penalty settled claims that the hospital billed Medicare, Medicaid and the military's Tricare program for unnecessary procedures between 1997 and 2002.[22] In follow-up settlements related to the case, Tenet sold Redding Medical Center and paid millions to the California Department of Insurance and two whistleblowers involved in the case, and hundreds of millions to the patients impacted by unnecessary surgeries.[23]

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[21] Karen Bouffard. "Tenet Healthcare buying DMC owner Vanguard Health for $1.8B," *The Detroit News*. June 24, 2013

[22] Dorsey Griffith, Sam Stanton and Denny Walsh. "Tenet to pay in heart cases; The $54 million deal avoids some civil, criminal actions in the Redding probe," *Sacramento Bee*. August 7, 2003.

[23] Sam Stanton and Denny Walsh. "Redding doctors won't be charged; But millions in civil penalties will be levied in medical fraud case," *Sacramento Bee*. November 16, 2005; Julie Appleby. "Tenet accused of $1 billion Medicare fraud," *USA Today*. March 3, 2005.

In 2006, Tenet Healthcare agreed to pay the U.S. government more than $900 million (the largest pay-out to date) for allegedly overbilling Medicare by manipulating the program's payment rules and paying kickbacks to physicians who referred patients to its facilities. As a result, Tenet was forced sell 11 of its hospitals to cover the costs. The following year, Tenet paid another $10 million to settle an SEC investigation of Medicare billing and fraudulent accounting practices.[24]

In 2012, Tenet agreed to pay over $42.75 million to settle another round of Medicare fraud allegations. Between 2005 and 2007, Tenet billed Medicare for treating patients at inpatient rehabilitation facilities when these patient stays did not meet the standards to qualify for inpatient care, in violation of the False Claims Act.[25]

And just this month, it was revealed that a former healthcare CFO filed a whistleblower charge in 2009 alleging that Tenet Healthcare paid kickbacks to clinics that directed undocumented pregnant women to give birth in its hospitals, and then filed fraudulent Medicaid claims on those patients. The lawsuit had been sealed by the Department of Justice pending the completion of its own investigation.[26] In year after year and state after state, Tenet Healthcare has demonstrated its willingness to defraud the government and taxpayers to reap financial rewards, and the real costs have been shouldered by its hospitals, which have been sold off or undercut to cover the costs of legal settlements.

In Connecticut, the Tenet takeover is perhaps the most unsettling. Tenet has announced that it plans to complete the deal by the end of 2013, roughly the same time Vanguard Health Systems has projected completing its acquisition of Greater Waterbury Health Network. If this is the case, the likelihood is that the Attorney General and Office of Health Care Access could approve GWHN's venture with an entity that no longer exists and, instead, be doing business with a corporation with major financial problems and an extensive history of fraud.

It would be prudent for Connecticut regulators to closely scrutinize these factors while considering Vanguard's petition for transfer of ownership of the Danbury and Waterbury hospitals. Since the Vanguard sale to Tenet has already been announced, the most prudent course of action would be to require due diligence of Tenet as well as Vanguard when considering the suitability of the transfer of ownership of the Connecticut facilities.

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[24] Bob Moos. "Tenet to pay to end SEC probe Dallas-based hospital operator was accused of Medicare scheme," *The Dallas Morning News.* April 3, 2007.

[25] Jim Landers. "Tenet settling overbill case," *The Dallas Morning News.* April 11, 2012; Jeffrey Young. "Tenet Healthcare 'Proud' To Settle Medicare Fraud Charges For $43 Million," *The Huffington Post.* April 11, 2012

[26] Kate Brumback. "Whistleblower suit: Hospitals defrauded Medicaid," *USA Today.* August 1, 2013.